IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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CERTIFIED MAIL: 7007 0710 0002 7979 0291

September 9, 2008

Robert Collette
Aspen Home Health Services
P.O. Box 3881
Idaho Falls, Idaho 83403

RE: Aspen Home Health Services, provider #137081

Dear Mr. Collette:

Based on the Medicare/Licensure survey completed at Aspen Home Health Services on August 29, 2008, by our staff, we have determined that Aspen Home Health Services is out of compliance with the Medicare Home Health Condition of Participation on Medical Social Services (42 CFR 484.34) and Comprehensive Assessment of Patients (42 CFR 484.55). To participate as a provider of services in the Medicare program, a Home Health Agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limits the capacity of Aspen Home Health Services to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **October 3, 2008. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than September 25, 2008.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.07.003, Aspen Home Health Services is being issued a Provisional Home Health license. The license is enclosed and is effective August 29, 2008, through December 29, 2008. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.07.003.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by October 7, 2008. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid - DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208)364-1804
fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

cc: Steve Millward
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief

The Aspen Group, Inc.

Aspen Home Health and Hospice

3470 Washington Parkway
Idaho Falls, Idaho 83404

Via Federal Express Tracking No: 9268 9487 9109

September 19, 2008

Silvia Crestwell, Supervisor
Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705

Re: Plan of Correction – Aspen Home Health
Medicare Provider No.13-7081

Dear Silvia:

Enclosed you will find our Credible Allegations in response to the survey conducted August 29, 2008.

Please extend again to your staff our thanks for the professional and thoughtful manner in which the survey was conducted.

If there is any other information I can provide just let me know.

Best Regards:

Robert Collette
Administrator

/s
enclosure (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137081	A. BUILDING _____ B. WING _____	08/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOME HEALTH SERVICES	3470 WASHINGTON PKWY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the recertification survey were: Gary Guiles, RN, HFS, Team Leader Sylvia Crestwell, NLTC Supervisor Patrick Hendrickson, RN, HFS Sharon Mauzy, RN, HFS Acronyms used in this report: ADL = Activity of Daily Living ALF = Assisted Living Facility BG = Blood Glucose level HHA = Home Health Agency IADL = Instrumental Activity of Daily Living MRSA = Methicillin-resistant Staphylococcus MSW = Medical Social Worker Ph.D. = Doctor of Philosophy POC = Plan of Care SNF = Skilled Nursing Facility SOC = Start of Care SWA = Social Work Assistant	G 000	Please refer to the attached **Appendix I** for all plans of correction.	
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on policies, staff interview and personnel record review, it was determined the HHA failed to ensure the administrator maintained	G 141	RECEIVED SEP 22 2008 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 9/19/2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 141	Continued From page 1 documentation of current professional licenses for 7 of 13 employees (#'s 2, 5, 8, 9, 12, 13 and 14) whose employee files were reviewed. By not ensuring that employees had current licenses the HHA could not ensure that cares are being provided by licensed staff. The findings include: The HHA's "EMPLOYEE FILES" policy, revised on 4/15/99, stated "personnel files will be maintained on all Home Health employees and will contain, at minimum, the following information...A copy, or evidence of, any professional licensure and/or state certification." Personnel records did not include current copies of professional licenses as follows: 1. Employee #2 was a Registered Nurse at the HHA during the time of the survey. The agency's employee file for Employee #2 did not contain a current license. 2. Employee #5 was a Home Health Aide at the HHA during the time of the survey. The agency's employee file for Employee #5 did not contain a current license. 3. Employee #8 was a Licensed Social Worker at the HHA during the time of the survey. The agency's employee file for Employee #8 did not contain a current license. 4. Employee #9 was a Speech Therapist at the HHA during the time of the survey. The agency's employee file for Employee #9 contained a license that had expired on 10/07. 5. Employee #12 was an Occupational Therapist at the HHA during the time of the survey. The	G 141	Please refer to the attached **Appendix I** for all plans of correction.	

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G 141	Continued From page 2 agency's employee file for Employee #12 contained a license that had expired on 4/08. 6. Employee #13 was a Ph. D. Social Worker at the HHA during the time of the survey. The agency's employee file for Employee #13 did not contain a current license. 7. Employee #14 was a Physical Therapist at the HHA during the time of the survey. The agency's employee file for Employee #14 contained a license that had expired on 6/08. On 8/14/08 at 9:30 PM, the HHA's Clinical Support Associate/Administrative Assistant reviewed the employee files. She confirmed the above information as accurate.	G 141	Please refer to the attached **Appendix I** for all plans of correction.	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of patient records, agency policies, and staff and patient interviews, it was determined the agency failed to ensure services provided were timely and consistent with the written plan of care established by a physician for 4 of 19 patients (#s 2, 6, 9 and 11), whose records were reviewed. This resulted in extra and missed patient visits, a significant delay in the evaluation and treatment of a patient ordered to receive OT services, and lack of a POC for nursing services that were provided to a patient. The findings include:	G 158		

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G 158	Continued From page 3 1. Patient #2, a 79-year-old male with a SOC date of 7/9/08, was admitted to home health for after care following a fall that fractured his left shoulder. The HHA's POC, dated 7/9/08, called for the patient to have an Occupational Therapy evaluation and Home Health Aide services. The Home Health Aide was to see the patient one time during the first week of service followed by two times a week for eight weeks. The patient was hospitalized during the second week of service from 7/14/08 to 7/16/08. He resumed home health services, per physician order, on 7/17/08. On 7/17/08 the physician, again, ordered an Occupational Therapy evaluation. The Occupational Therapist did not evaluate the patient until 7/21/08, 12 days from the original order on 7/9/08. On the same date, the physician ordered Home Health Aide services one time that week and then two times a week for 7 weeks. The only documented Home Health Aide visit was on 7/10/08. During an interview on 8/13/08 at 10:30 AM, the Occupational Therapist stated he had trouble scheduling the patient's initial evaluation. He said it was the HHA office staff's duty to inform the physician of the delay in the evaluation. On 8/13/08 at 10:50 AM, the patient stated he received only one visit from the home health aide. He said he felt uncomfortable having a "young girl bathe him". On 8/13/08 at 3:15 PM, the HHA's Clinical Coordinator stated Occupational Therapy evaluations were to be done within 72 hours from the date of the referral. She reviewed the patient's record and stated the office staff did not notify the physician of the delay. She was unaware of the Home Health Aide situation and had not obtained orders to discontinue the aide services. 2. Patient #6, a 62-year-old female with a SOC	G 158	Please refer to the attached **Appendix I** for all plans of correction.	

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G 158	Continued From page 4 date of 7/18/08, was admitted to home health with for after care of healing trauma. The HHA's POC, dated 7/18/08, called for the patient to have Home Health Aide services starting on the patient's second week of service three times per week for eight weeks. During the second week of services, two Home Health Aide visits were documented. During an interview on 8/14/08 at 3:30 PM, the HHA's Clinical Coordinator reviewed Patient #6's record. She confirmed that the patient had missed a visit from the Home Health Aide during the second week of service and could not find documentation the physician had been notified of the missed visit. On 8/14/08 at 3:40 PM, the aide stated the patient had refused the third visit during the second week of service. She said she did not tell anyone of this missed visit. 3. Patient #11, an 82-year-old male with a SOC date of 4/15/08, was admitted to home health with a principle diagnosis of "Late effects of acute poliomyelitis". The home health Physical Therapy POC, dated 4/16/08, called for Physical Therapy visits two times per week for three weeks, followed by three times per week for two weeks. During the third week of care, three Physical Therapy visits were documented. No physician's order was found in the clinical record for the extra visit or documentation that the physician had been notified that an extra visit was necessary. During an interview, on 8/14/08 at 3:30 PM, the HHA's Clinical Coordinator reviewed Patient #11's record. She confirmed that the patient had an extra visit from the Physical Therapist during the third week of care and could not find documentation that the physician had ordered the extra visit. 4. Patient #16 was an 83 year old male with a	G 158	Please refer to the attached **Appendix I** for all plans of correction.	

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G 158	Continued From page 5 diagnosis of abnormal gait and a history of congestive heart failure, diabetes, stroke, hypothyroidism, and chronic obstructive pulmonary disease. His SOC was 6/20/08. His admitting orders, dated 6/20/08, stated the RN was to visit the patient one time to evaluate him. This was done on 6/20/08. An order for the nurse to visit the patient weekly was obtained on 7/2/08. No POC for the nurse was found in the record. This was confirmed by the Supervising Nurse who reviewed the record on 8/14/08 at 2 PM.	G 158	Please refer to the attached **Appendix I** for all plans of correction.	
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview it was determined the agency failed to develop a plan of care that addressed all appropriate items for 1 of 19 patients (#14) whose records were reviewed. This resulted in the potential for patients' not being provided medical care as directed by a physician. The findings included: 1. Patient #14, a 76-year-old female with a SOC date of 4/27/07, was admitted to home health with a principle diagnosis of "PERNICIOUS ANEMIA". The patient lived with a family member who was	G 159		

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G 159	Continued From page 6 the patient's primary caregiver. The family member assisted the patient with medications, ADL's and the care of her ileostomy. The patient's POC, dated 6/20/08, stated that nursing staff were to assess the patient two times a week and give the patient a B12 injection once a week. On 8/14/08 at 12:30 PM, the patient was observed to be cognitive, functional and could ambulate without assistance. The patient's POC dated 6/20/08, listed the following goals: "(1) Patient's pain level will decrease to acceptable level < 5/10 by the end of certification period; (2) Patient's nausea will be controlled with current medication by end of certification period; (3) Patient will tolerate B12 injections without any adverse reaction through certification period." The plan of care developed did not cover plans for a timely discharge or referral. On 8/14/08 at 2:30 PM, the Clinical Director of the HHA's Blackfoot office was interviewed. She reviewed the patient's POC and could not find where the POC had been developed to include planning for a timely discharge or referral.	G 159	Please refer to the attached **Appendix I** for all plans of correction.	
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure nursing staff initiated POC updates for 3 of 19 patients (#'s 10, 11 and 16), whose records were reviewed. This resulted in a lack of patient POCs related to (1) Specialized infection control practices for a patient diagnosed with MRSA; 2) Lack of monitoring of a patient for	G 173		

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G 173	Continued From page 7 signs/symptoms of abuse by caregivers and serious mismanagement of the patient's medications by caregiver and 3) the provision of nursing services to a patient without a POC. The findings include: 1. Patient #11, an 82-year-old male with a SOC date of 4/15/08, was admitted to home health with a principle diagnosis of "Late effects of acute poliomyelitis". On 5/9/08 the physician wrote an order for staff to collect a culture swab of a superficial wound on the patient's right foot because of a possible infection. The culture results were called to the HHA by the lab on 5/12/08 at 1:30 PM. The patient's wound was infected with MRSA. The Clinical Director was interviewed on 8/15/08 at 8:30 AM. She said the HHA would implement specialized infection control procedures for patients who had been diagnosed with MRSA. She said that patient #11's POC should have been updated to reflect the necessity for the infection control practices. She confirmed the patient's POC was not updated to guide staff on the treatment and prevention of the spread of the MRSA. 2. Patient #10 was a 68 year old female whose SOC was 12/19/07. Diagnoses included total hip replacement on 11/26/08, decubitus ulcer, and diabetes. Home health was ordered because the patient was moving from the SNF to a private residence. A referral sheet was faxed to the agency from the SNF where the patient resided on 12/18/07. The cover sheet stated "Adult Protection referral has been made." A nursing assessment was conducted on 12/19/07. The assessment documented the patient was an insulin dependent diabetic but the BG level was not documented. The POC, dated 12/19/07,	G 173	Please refer to the attached **Appendix I** for all plans of correction.	

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G 173	Continued From page 8 called for a nurse to visit the patient 2 times a week "...to assess pressure ulcers on coccyx, assess pt. needs, teach foley care to husband." A specific procedure for wound care was also listed. The POC did not address steps to monitor the patient for abuse/neglect due to the perceived risk as noted by the referral to Adult Protection. The POC also did not address the patient's diabetes. A nursing visit to Patient #10 was documented on 12/22/07 at 10:30 AM. The nursing note stated the patient's BG had been 430-450 prior to the visit. Normal fasting BG levels are 70-100 according to the National Institutes of Health. High BG levels can lead to ketoacidosis and death. The nurse did not measure the patient's BG level during the 12/22/07 visit in order to determine what the patient's BG currently was. Communication with the family regarding the diabetes was also not documented. The nursing visit note for 12/24/07 at 12:25 PM did not document the patient's current or previous BG. The 12/24/07 note did state "Husband helped pt to walk to bed, as he was getting her in bed she stated 'Don't hit me again.' As far as I could see, he wasn't." No other documentation regarding the possible abuse was present in the record for this visit. A nursing visit note for 12/27/07 at 12:00 noon documented Patient #10's BG at the time as 388. The note said the patient's husband and daughter "States pt had seizure last night (BG greater than) 500-no insulin given. This AM-'around 300-400'...& husband states no insulin given because not eating. Talked with both to start (antibiotic) & give long acting insulin whether she eats or not. 'Oh, we have been doing it wrong.'	G 173	Please refer to the attached **Appendix I** for all plans of correction.	

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G 173	Continued From page 9 Pt very lethargic today, disheveled...Pt has not let MSW in yet." A "Coordination of Care Report" written by the nurse, dated 12/27/07, stated "Dr. [name] - FYI [Patient's name] has not been given her antibiotic you prescribed or that Dr. [name] prescribed for UTI. Both husband and daughter didn't think it was important. I talked to them both & told them it is very important to take them. Also they don't give any insulin & her husband states blood sugars are always 300-400 or greater. Both daughter & husband seem confused about insulin & said 'We have been doing it wrong'." The next nursing visit was 12/31/07 at 12 noon. The note stated the patient's BG was "300-500". A BG at the time of the visit was not documented. This was the last nursing visit. The patient was readmitted to the hospital on 1/3/08 for complications received in a fall. The POC was not changed to reflect the poor management of the patient's diabetes or the potential abuse. The RN Case Manger for Patient #10 was interviewed on 8/13/08 at 3:50 PM. She reviewed the medical record and confirmed the plan did not address the diabetes or potential abuse. She said she had known the patient prior to her admission to home health and she did not take the patient's situation as seriously as she should have. #3. Patient #16 was an 83 year old male with a diagnosis of abnormal gait and a history of congestive heart failure, diabetes, stroke, hypothyroidism, and chronic obstructive pulmonary disease. His SOC was 6/20/08. He was currently a patient as of 8/13/08. The patient's POC, dated 6/20/08, called for a one time visit from the nurse to assess the patient. This was made on 6/20/08. On 7/2/08, the	G 173	Please refer to the attached **Appendix I** for all plans of correction.	

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G 173	Continued From page 10 agency obtained an order for nursing to visit the patient one time a week for the duration of the certification period (through 8/18/08). A POC for nursing was not documented in the record. This was confirmed by the Clinical Coordinator on 8/14/08 at 2 PM.	G 173	Please refer to the attached **Appendix I** for all plans of correction.	
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical records and staff interviews, it was determined the agency failed to ensure nursing informed the physician of changes in patient conditions for 3 of 19 patients (#s 10, 13 and 15) whose records were reviewed. This failure can result in the potential for patients' needs not to be met. The findings include: 1. Patient #15 was an 81-year-old male who was admitted to the HHA on 8/5/08 for aftercare following a total hip. An un-timed Skilled Nursing note, dated 8/7/08, stated the patient had a temperature of 100.1, pain with deep breaths, oxygen saturations of less than 90%, and decreased breath sounds in his left lung. There was no documented evidence that the nurse notified the physician of the above symptoms until the patient's next visit on 8/8/08, when she noted the same observations. Nursing staff failed to inform the physician of the changes in the patient's condition.	G 176		

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G 176	Continued From page 11 2. Patient #10 was a 68 year old female whose SOC was 12/19/07. Diagnoses included total hip replacement on 11/26/08, decubitus ulcer, and diabetes. Home health was ordered because the patient was moving from the SNF to a private residence. A referral sheet was faxed to the agency from the SNF where the patient resided on 12/18/07. The cover sheet stated "Adult Protection referral has been made." A nursing assessment was conducted on 12/19/07. The assessment documented the patient was an insulin dependent diabetic but the BG was not documented. The POC was developed following the nursing assessment. The POC called for a nurse to visit the patient 2 times a week "...to assess pressure ulcers on coccyx, assess pt. needs, teach foley care to husband." A specific procedure for wound care was also listed. A nursing visit to Patient #10 was made on 12/22/08 at 10:30 AM. The nursing note stated the patient's BG had been 430-450. Normal fasting BG levels are 70-100 according to the National Institutes of Health. High BG levels can lead to ketoacidosis and death. A BG at the time of the visit was not documented. Communication with the family regarding the diabetes was not documented. The nursing visit note for 12/24/07 at 12:25 PM did not document the patient's BG. The 12/24/07 note did state "Husband helped pt to walk to bed, as he was getting her in bed she stated 'Don't hit me again.' As far as I could see, he wasn't." A nursing visit note for 12/27/07 at 12:00 noon documented the patient's BG at the time as 388. The note said the patient's husband and daughter "States pt had seizure last night (BG greater than) 500-no insulin given. This AM-'around 300-400'...&husband states no insulin given because not eating. Talked with both to	G 176	Please refer to the attached **Appendix I** for all plans of correction.	

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G 176	Continued From page 12 start (antibiotic) & give long acting insulin whether she eats or not. 'Oh, we have been doing it wrong.' Pt very lethargic today, disheveled...Pt has not let MSW in yet." A "Coordination of Care Report" written by the nurse, dated 12/27/07, stated "Dr. [name] - FYI [Patient's name] has not been giving her antibiotic you prescribed or that Dr. [name] prescribed for UTI. Both husband and daughter didn't think it was important. I talked to them both & told them it is very important to take them. Also they don't give any insulin & her husband states blood sugars are always 300-400 or greater. Both daughter & husband seem confused about insulin & said 'We have been doing it wrong'." I will also let Dr. [name] and her primary MD know." However, a Coordination of Care Report, dated 12/27/07, stated "Talked with [name of Medial Assistant] at Dr. [name's] office. Related husband not giving insulin like he should, or daughter. She will speak (with) Dr. [name]." No further documentation was present stating the physician received the message. No documentation was present to show the nurse faxed another physician. The next nursing visit was 12/31/07 at 12 noon. The note stated the patient's BG was "300-500". A BG at the time of the visit was not documented. This was the last nursing visit. The patient was readmitted to the hospital on 1/3/08 for complications received in a fall. The RN Case Manger for Patient #10 was interviewed on 8/13/07 at 3:50 PM. She reviewed the medical record and confirmed the documentation as noted above. She said she did not attempt to notify the physician of the patient's high BG until 12/27/07. She acknowledged the holidays between Christmas and New Years and stated she did not know if the physician received	G 176	Please refer to the attached **Appendix I** for all plans of correction.	

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G 176	Continued From page 13 the message or not. She said she did not follow up to make sure the physician responded to the message. The nurse failed to notify the patient's physician of changes in the patient's blood glucose levels.	G 176	Please refer to the attached **Appendix I** for all plans of correction.	
G 194	484.34 MEDICAL SOCIAL SERVICES This CONDITION is not met as evidenced by: Based on review of medical records and agency policies and staff interview, it was determined the agency failed to provide social services in accordance with acceptable standards. The agency failed to ensure services were provided by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. Refer to G195 as it relates to the failure of the agency to ensure social services were provided by qualified personnel. Refer to G196 as it relates to the failure of the agency to ensure complete social service POCs were developed. Refer to G201 as it relates to the failure of the agency to ensure the social worker acted as a consultant to agency personnel. The cumulative effect of these systemic practices resulted in the inability of the agency to provide social services to meet patient needs.	G 194		
G 195	484.34 MEDICAL SOCIAL SERVICES If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. The	G 195		

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G 195	Continued From page 14 social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems. This STANDARD is not met as evidenced by: Based on review of clinical records, personnel records, agency policies, and staff interview, it was determined the agency failed to ensure medical social services were provided by a qualified Social Worker or by a qualified SWA under the supervision of a qualified Social Worker. The agency also failed to ensure social services were provided in accordance with the POC. The agency failed to provide social services for 4 of 5 sampled patients (#s 6, 14, 16 and 17), who had orders for the service. The failure of the agency to provide adequate social services resulted in the inability of the agency to meet patients' psychosocial needs. The findings include: 1. Personnel records documented the agency employed a social worker with a doctoral degree in social work and a LSW who had a bachelors degree in social work who served as a social worker assistant. 42 CFR Part 484.4 defines Social Worker as "A person who has a master's degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting." 42 CFR Part 484.4 also defines Social Work Assistant as "a person who: (1) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting". The Ph.D. Social Worker was interviewed on 8/15/08 at 9:34	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 15 AM. He stated he did not provide services to patients in Idaho Falls, the largest town in the agency's service area. He said all social services in Idaho Falls were provided by the SWA. Social Service assessments and POCs were incomplete and had not been followed. Documentation of services provided by the MSW were not present. The agency failed to ensure a system had been developed to ensure the MSW participated in the care of patients and also provided oversight to the SWA. The agency failed to develop job descriptions and policies to outline a framework for the provision of Social Services and reflect agency practices. The job description for Medical Social Worker, dated 1997 and last reviewed 2/07, stated "Medical Social Services...are given by a qualified social worker and in accordance with the plan of treatment." Job specifications for the position included "Masters of Science degree in social work (or bachelors degree with experience, under the supervision of a masters-prepared individual)..." The policy "MEDICAL SOCIAL SERVICES", dated 1997 and last reviewed 2/07, stated all services would be given by a qualified social worker. Neither this policy nor the job description specified the difference in duties between the 2 staff or how the MSW was to supervise the SWA and how this would be documented. This was confirmed by interview with the SWA on 8/14/08 at 3:10 PM. She stated she was not aware of a specific policy that described her job duties or a policy regarding how she was to be supervised by the MSW. 2. The Social Worker had not supervised the SWA to ensure that POCs were developed and medical social services were provided to meet	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 16 patient's needs. Examples include: A. Patient #17 was an 89 year old male with a diagnosis of pyelonephritis (inflamed kidney), congestive heart failure, and a history of stroke. His SOC was 4/26/08. A nursing note, dated 7/8/08, stated "Caregiver (spouse) reports pt fell out of bed this AM & she could not get him up. She called neighbors. Pt has weakness X 4-5 days caregiver reports (increased) depression-'he won't talk to me.' She has failing health and stressors she verbalized including (history) of financial exploitation by (patient's daughter)...She states she had stolen checks & pt credit card while pt in hospital (with) bills of $400.00-1000.00 while in (hospital). She fears her own financial needs. She states they took out reverse mortgage on home to live on but continues with concerns of financial exploitation. She also stated pt dtr took their car. MSW eval ordered." The SWA visited the patient and his spouse on 7/11/08 and completed a "Medical Social Services Assessment Plan of Care & Telephone Orders" form. The form contained checked boxes stating the patient was oriented and had "No social/emotional dysfunction identified". The form stated the patient's finances were "Inadequate", but did not describe what this meant. A more complete assessment of the patient's finances was not documented. The primary caregiver, the patient's wife, was described as "very frail-poor health". After an item about support outside the family was written "(zero) abusive daughter who takes advantage of them". Under "Problems/Needs Identified:" was listed "Respite care, meal prep, homemaking, bathing, family member-taking money-credit	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 17 cards". Patient goals were listed as "Patient will have access to community support, resources to maintain independence in home." The plan included a checked box for "Assessment of social/emotional function" and a checked box for "Community resource planning:" after which was written meals on wheels, homemaker, bath aide, connected to "Free Meds", discussed long range planning and hospice services, assist with financial matters. The plan requested was for "1 or prn" visits for 10 weeks. A note by the SWA accompanied the assessment. It stated both the patient and his spouse were experiencing increased medical problems. The note listed some services potentially available to the patient and spouse, such as meals on wheels. The note did state the patient had a daughter who had stolen money and credit cards and had been "abusive" to them. The note said "Will assist [name] with getting more control over financial matters and make referrals to adult protection if needed. [name] has taken steps already to keep her from their accounts." The assessment and note did not specifically assess the patient or spouse's depression or stressors. Also a specific plan to have agency staff monitor the patient and spouse for abuse/exploitation by the daughter was not developed. A coordination of care note by the SWA on 7/15/08 stated she talked with the spouse by telephone. It said the daughter was threatening to come over and take the patient to the bank to withdraw money. The note said the daughter had been verbally abusive. The SWA gave the spouse the number for Adult Protection and told the spouse to call 911 if the daughter refused to leave. The SWA visited on 7/16/08. She provided information on financial resources. Her note, dated 7/16/08, stated "Spoke to [name] about Adult Protection. Gave her a handout on	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 18 different areas of Adult Protection-wrote contact phone number. [Patient's] daughter has been abusive (physically) in the past and has been using credit cards w/o permission as recently as 6 months ago. They didn't want to report for past issues but [spouse] is ready and willing to start if anything happens again. I will check back next week to make sure aging office has contacted them." Neither this note nor the assessment specifically documented the abuses such as how much money was taken and when, what efforts were taken to get the daughter to return the money, and what specific physical and verbal abuse had occurred. The next and last note by the SWA was a "FINAL REPORT PHYSICIAN'S DISCHARGE ORDER/SUMMARY", dated 7/22/08. It stated the patient was "Stable. Patient and family connected to community resources & support services...Linked family to Adult protection phone number-for family issues (with) adult daughter taking advantage of them..." A visit was not made on 7/22/08. A plan for agency staff to continue to monitor the patient and caregiver for social service issues had not been developed. Documentation of supervision of the SWA and the care provided to Patient #17 was not present in the record. The Ph.D. Social Worker signed the Assessment/POC on 2/21/08 (10 days after the assessment) but no notes by the Ph.D. Social Worker were present in the chart. The SWA was interviewed on 8/14/08 at 3:10 PM. She stated she assessed Patient #17 and then talked to the Ph.D. Social Worker but did not document this. She stated she did not discuss the patient with the Ph.D. Social Worker after 7/11/08. She said she did not report the abuse to Adult Protection because the patient's wife did not wish her to and	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 19 believed empowering the spouse and patient was important. She confirmed there was no ongoing plan to monitor the patient for social service problems. Social services for patient #17 were not provided by a MSW and were inadequate to meet the patient's needs. B. Patient #16 was an 83 year old male with a diagnosis of abnormal gait and a history of congestive heart failure, diabetes, stroke, hypothyroidism, and chronic obstructive pulmonary disease. His SOC was 6/20/08. His admitting nursing assessment, dated 6/20/08, stated he had a history of left "...knee pain, weakness, lives alone on 2nd floor apt. Hard to get out. Has walker & [motorized scooter]..." Nursing notes on 6/27/08, 7/2/08, and 7/11/08 described the patient having difficulty with ambulation, edema, and wheezing. The Medical Social Services Assessment Plan of Care & Telephone Orders form was completed on 6/24/08 by the SWA. It stated the patient was independent with ADLs "with some memory problems" and used a walker. The assessment stated the patient lived alone and had a son in a town approximately 32 miles away. The assessment stated the patient was "looking to move to Sr. Apts." The POC stated social work interventions to be provided were "Assessment of social/emotional function" and "Community resource planning: [medical alert] -Aging Office, Sr. Apts". The assessment/POC was signed by the Ph.D. Social Worker on 7/6/08, 12 days later. No other documentation by the Ph.D. Social Worker was present in the record. An accompanying note by the SWA on 6/24/08, stated the patient had "just finished a 100 day stay at a (skilled nursing facility). He has great trouble getting around-uses a walker. Short of	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 20 breath-diabetic-had a stroke 3 yrs ago & CHF. He lives alone in an upstairs apartment. He has a son who lives in [town name] who is POA and does his shopping-errands, etc...Referrals made to Sr. apts-where he will not be living on 2nd floor (with) stairs...Son will help him call Sr apts & go visit them. No further visits needed." The SWA, interviewed on 8/14/08 at 3:10 PM, stated the physician and nurse were concerned that the patient lived in a second floor apartment and had problems caring for himself. She said that, as of 8/14/08, the patient had not moved. The social service assessment had a checked box finances were "Adequate" with no details. The SWA said his finances were not adequate to move to the senior apartments. She did not know the specifics of his finances. She said she had not conducted any further visits to the patient and had not followed up regarding the patient's failure to move to more accessible housing. Social services for patient #17 were not provided by a MSW and were inadequate to meet the patient's needs. C. Patient #14 was a 76-year-old female with a SOC date of 4/27/07. She was admitted to the home health agency with a principle diagnosis of "PERNICIOUS ANEMIA". She was currently a patient as of 8/14/08. On 4/18/08, the patient's physician ordered a MSW evaluation. The record contained a "Social Worker Note", dated 4/19/08 at 2:10 PM, which stated "Patient's daughter requested a meeting to discuss options for their mother. Currently she is residing with one of her daughters. Family had concluded about a year ago that she was no longer safe to be alone in her townhome [sic]. Daughter described their mother as requiring care with all ADL's, constant	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 21 supervision. Discussed option including inpatient care ALF, SNF, probable costs. Daughter indicated her resources are limited, the only substantial resource she has is her townhome [sic]. She lives on social security. Provided general information regarding Medicaid edibility. Discussed hospice in-depth....". The Ph.D. Social Worker did not complete a "Medical Social Services Assessment Plan of Care & Telephone Orders" form as required by the agency to aid in a complete psychosocial evaluation. No other assessment of the patient's social service needs was documented. This was confirmed during an interview with the Ph.D. Social Worker on 8/15/08 at 9:34 AM. The next and final note by the Ph.D. Social Worker in Patient #14's record was a "Summary of Discussion/Report", dated 4/22/08. It stated "Called patient's daughter re; [regarding] possible hospice care. Daughter indicated that her mother was not ready for hospice. She did not wish for me to discuss hospice with her mother." During a home visit on 8/14/08 at 12:30 PM, the patient was observed to be cognitive and functional. There was no documentation the Ph.D. Social Worker had assessed Patient #14's ability to make her own medical decisions. There was no documentation the Ph.D. Social Worker had informed Patient #14 of her condition, her options for care, or her rights. No plan was documented for agency staff to continue to monitor the patient's social issues. This was confirmed during an interview with the Ph.D. Social Worker on 8/15/08 at 9:34 AM. E. Patient #6 was a 62-year-old female with a SOC date of 7/18/08. She was admitted to the home health agency for treatment following a	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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G 195	Continued From page 22 broken back. She was a patient as of 8/14/08. On 7/18/08, the patient's physician ordered a MSW evaluation and "assist with possible community resources". The record contained a "Medical Social Services Assessment Plan of Care and Telephone Orders" form, dated 7/24/08, that was completed by the SWA. The form stated the patient lived with her husband and was independent. It further stated, the patient was ambulatory and orientated with no social or emotional dysfunctions. The patient was referred to the Aging office for meals and homemaking services. The SWA discharged the patient on 7/29/08. The record contained no evidence the SWA had conducted the patient with any further visits or had followed up to see whether the patient had been approved to receive services from the Aging office. Additionally, the record did not contain that the SWA had been supervised by the Ph.D. Social Worker and that he was involved in any of the cares that was provided to Patient #6 by the SWA. The Ph.D. Social Worker further had signed the Assessment/POC on 8/08/08, 15 days after the assessment and 10 days after the patient was discharged. 3. The SWA was interviewed on 8/14/08 at 3:10 PM. She stated she visited patients and conducted the SW assessments. She said she then wrote the assessments and documented whether or not she planned another visit. She stated she then placed the assessment in the Ph.D. Social Worker in-box. She said she then called the supervising social worker and told him the assessment was available. The supervising social worked would review/signed them when he came into the office, which was 2-3 times a week. She said she spoke with the supervising social worker regarding only about half of the patients	G 195	Please refer to the attached **Appendix I** for all plans of correction.	

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	137081	A. BUILDING _____ B. WING _____	08/29/2008

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G 195	Continued From page 23 she saw. She said these exchanges were not documented. The SWA also indicated she participated in case conferences. 4. The supervising social worker was interviewed on 8/15/08 at 9:35 AM. He said he spoke with the SWA almost daily but did not document these exchanges. He stated he spoke with the SWA about Patient #17 but did not document the communications. He also stated he spoke with the agency nurses about various patients but did not document the communications. He confirmed he could not produce documentation regarding services he had provided to patients. He stated he had not participated in IDT meetings in the Idaho Falls office for years.	G 195	Please refer to the attached **Appendix I** for all plans of correction.	
G 196	484.34 MEDICAL SOCIAL SERVICES The social worker participates in the development of the plan of care. This STANDARD is not met as evidenced by: Based on review of clinical records, policies and staff interview, it was determined the MSW failed to participate in the development of the plan of care for 3 of 5 patients (#'s 14, 16, and 17) with social work services, whose records were reviewed. This resulted in the lack of comprehensive POCs for patients receiving social services. The findings include: 1. Patient #14 was a 76-year-old female with a SOC date of 4/27/07. She was admitted to the home health agency with a principle diagnosis of "PERNICIOUS ANEMIA". She was currently a patient as of 8/14/08. On 4/18/08, the patient's physician ordered a MSW evaluation. The record contained a "Social Worker Note", dated 4/19/08	G 196		

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G 196	Continued From page 24 at 2:10 PM, which stated "Patient's daughter requested a meeting to discuss options for their mother. Currently she is residing with one of her daughters. Family had concluded about a year ago that she was no longer safe to be alone in her town home. Daughter described their mother as requiring care with all ADL's [sic] constant supervision. Discussed option including inpatient care, ALF, SNF, probable costs. Daughter indicated her resources are limited, the only substantial resource she has is her townhouse. She lives on social security. Provided general information regarding Medicaid eligibility. Discussed hospice in-depth...." On 4/22/08, the MSW had documented that the family had refused hospice and told the agency to "not discuss hospice with her mother". The record did not contain a social service POC nor was the patient's POC (CMS Form 485) updated to reflect that the MSW had participated in the development of the POC. On 8/15/08 at 9:34 AM, the MSW stated that he would normally develop a POC for patients that he follows. He reviewed the patient's record and could not find a social service POC. No evidence was found to indicate a MSW POC was developed. 2. A complete POC had not been developed for Patient #17. The patient was an 89 year old male with a diagnosis of pyelonephritis (inflamed kidney), congestive heart failure, and a history of stroke. His SOC was 4/26/08. A nursing note, dated 7/8/08, stated "Caregiver (spouse) reports pt fell out of bed this AM & she could not get him up. She called neighbors. Pt has weakness X 4-5 days caregiver reports (increased) depression-'he won't talk to me.' She has failing health and stressors she verbalized including (history) of financial exploitation by (patient's	G 196	Please refer to the attached **Appendix I** for all plans of correction.	

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G 196	Continued From page 25 daughter)...She states she had stolen checks & pt credit card while pt in hospital (with) bills of $400.00-1000.00 while in (hospital). She fears her own financial needs. She states they took out reverse mortgage on home to live on but continues with concerns of financial exploitation. She also stated pt dtr took their car. MSW eval ordered." The SWA visited the patient and his spouse on 7/11/08 and completed a "Medical Social Services Assessment Plan of Care & Telephone Orders" form. The form contained checked boxes stating the patient was oriented and had "No social/emotional dysfunction identified". The form stated the patient's finances were "Inadequate", but did not describe what this meant. A more complete assessment of the patient's finances was not documented. The primary caregiver, the patient's wife, was described as "very frail-poor health". After an item about support outside the family was written "(zero) abusive daughter who takes advantage of them". Under "Problems/Needs Identified:" was listed "Respite care, meal prep, homemaking, bathing, family member-taking money-credit cards". Patient goals were listed as "Patient will have access to community support, resources to maintain independence in home." The plan included a checked box for "Assessment of social/emotional function" and a checked box for "Community resource planning:" after which was written meals on wheels, homemaker, bath aide, connected to "Free Meds", discussed long range planning and hospice services, assist with financial matters. The plan requested was for "1 or prn" visits for 10 weeks. The MSW signed the Assessment/POC on 2/21/08 (10 days after the assessment) but no notes by the MSW were present in the chart. The SWA was interviewed on 8/14/08 at 3:10 PM. She stated she assessed	G 196	Please refer to the attached **Appendix I** for all plans of correction.	

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G 196	Continued From page 26 Patient #17 and then talked to the MSW but did not document this. She stated she did not discuss the patient with the MSW after 7/11/08. She said no documentation was present to indicate the MSW had participated in the development of the POC. 3. Patient #16 was an 83 year old male with a diagnosis of abnormal gait and a history of congestive heart failure, diabetes, stroke, hypothyroidism, and chronic obstructive pulmonary disease. His SOC was 6/20/08. His admitting nursing assessment, dated 6/20/08, stated he had a history of left "...knee pain, weakness, lives alone on 2nd floor apt. Hard to get out. Has walker & [motorized scooter]..." Nursing notes on 6/27/08, 7/2/08, and 7/11/08 described the patient having difficulty with ambulation, edema, and wheezing. The Medical Social Services Assessment Plan of Care & Telephone Orders form was completed on 6/24/08 by the SWA. It stated the patient was independent with ADLs "with some memory problems" and used a walker. The assessment stated the patient lived alone and had a son in a town approximately 32 miles away. The assessment stated the patient was "looking to move to Sr. Apts." The POC stated social work interventions to be provided were "Assessment of social/emotional function" and "Community resource planning: [medical alert] -Aging Office, Sr. Apts". The assessment/POC was signed by the MSW on 7/6/08, 12 days later. No other documentation by the MSW was present in the record. No documentation was present to indicate the MSW had participated in the development of the POC. The SWA, interviewed on 8/14/08 at 3:10 PM, stated she had no evidence the MSW had participated in the	G 196	Please refer to the attached **Appendix I** for all plans of correction.	

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G 196	Continued From page 27 development of the POC. A complete POC had not been developed for this patient.	G 196	Please refer to the attached **Appendix I** for all plans of correction.	
G 201	484.34 MEDICAL SOCIAL SERVICES The social worker acts as a consultant to other agency personnel. This STANDARD is not met as evidenced by: Based on review of clinical records, policies and staff interview it was determined the MSW failed to act as a consultant to other agency personnel for 3 of 5 patients who had received social services (#'s 14, 16, and 17). The failure of the MSW to coordinate with other HHA staff resulted in an inconsistent approach between staff to meet patients social and emotional needs. The findings include: The Agency's "Various Job Descriptions" policy, dated 2/07, stated the MSW would assist other team members in understanding the significant social emotional factors related to the patients' health problems and acts as a consultant to other agency personnel. This had not occurred. Examples include: A. Patient #14, was a 76-year-old female with a SOC date of 4/27/07. She was admitted to home health with a principle diagnosis of "PERNICIOUS ANEMIA". She was currently a patient as of 8/14/08. On 4/18/08, the patient's physician ordered a MSW evaluation. The record contained a "Social Worker Note", dated 4/19/08 at 2:10 PM, that stated "Patient's daughter requested a meeting to discuss options for their mother. Currently she is residing with one of her daughters. Family had concluded about a year ago that she was no longer safe to be alone in	G 201		

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G 201	Continued From page 28 her town home. Daughter described their mother or requiring care with all ADL's (Activity Of Daily Living), constant supervision. Discussed options including inpatient care, ALF (Assisted Living Facility), SNF(Skilled nursing Facility), probable costs. Daughter indicated her resources are limited, the only substantial resource she has is her townhouse. She lives on social security. Provided general information regarding Medicaid eligibility. Discussed hospice in-depth...." On 4/22/08 the MSW documented the family had "refused hospice" and told the agency to "not discuss hospice with her mother." On 8/15/08 at 9:34 AM, the MSW stated that he did not consult with the other HHA's staff involved in the patient's care. He further stated that he did not attend any of the HHA's IDT meetings to cordinate services. The MSW failed to act as a consultant to other agency personnel and did not coordinate with staff in order to meet the patients' psychosocial needs. B. Patient #17 was an 89 year old male with a diagnosis of pyelonephritis (inflamed kidney), congestive heart failure, and a history of stroke. His SOC was 4/26/08. A nursing note, dated 7/8/08, stated "Caregiver (spouse) reports pt fell out of bed this AM & she could not get him up. She called neighbors. Pt has weakness X 4-5 days caregiver reports (increased) depression-'he won't talk to me.' She has failing health and stressors she verbalized including (history) of financial exploitation by (patient's daughter)...She states she had stolen checks & pt credit card while pt in hospital (with) bills of $400.00-1000.00 while in (hospital). She fears her own financial needs. She states they took out reverse	G 201	Please refer to the attached **Appendix I** for all plans of correction.	

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G 201	Continued From page 29 mortgage on home to live on but continues with concerns of financial exploitation. She also stated pt dtr took their car. MSW eval ordered." The SWA visited the patient and his spouse on 7/11/08 and completed a "Medical Social Services Assessment Plan of Care & Telephone Orders" form. The form contained checked boxes stating the patient was oriented and had "No social/emotional dysfunction identified". The form stated the patient's finances were "Inadequate", but did not describe what this meant. A more complete assessment of the patient's finances was not documented. The primary caregiver, the patient's wife, was described as "very frail-poor health". After an item about support outside the family was written "(zero) abusive daughter who takes advantage of them". Under "Problems/Needs Identified:" was listed "Respite care, meal prep, homemaking, bathing, family member-taking money-credit cards". Patient goals were listed as "Patient will have access to community support, resources to maintain independence in home." The plan included a checked box for "Assessment of social/emotional function" and a checked box for "Community resource planning:" after which was written meals on wheels, homemaker, bath aide, connected to "Free Meds", discussed long range planning and hospice services, assist with financial matters. The plan requested was for "1 or prn" visits for 10 weeks. A note by the SWA accompanied the assessment. It stated both the patient and his spouse were experiencing increased medical problems. The note listed some services potentially available to the patient and spouse, such as meals on wheels. The note did state the patient had a daughter who had stolen money and credit cards and had been "abusive" to them. The note said "Will assist	G 201	Please refer to the attached **Appendix I** for all plans of correction.	

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G 201	Continued From page 30 [name] with getting more control over financial matters and make referrals to adult protection if needed. [name] has taken steps already to keep her from their accounts." The record did not contain documentation to support that the MSW or SWA had communicated with other agency staff in order to monitor the patient's psychosocial needs or instruct staff regarding actions to take if the patient's daughter exhibited abusive behavior. The SWA was interviewed on 8/14/08 at 3:10 PM. She was not able to state what specifically what what had been discussed with other staff. The social worker did not act as a consultant to staff in relation to Patient #17. C. Patient #16 was an 83 year old male with a diagnosis of abnormal gait and a history of congestive heart failure, diabetes, stroke, hypothyroidism, and chronic obstructive pulmonary disease. His SOC was 6/20/08. His admitting nursing assessment, dated 6/20/08, stated he had a history of left"...knee pain, weakness, lives alone on 2nd floor apt. Hard to get out. Has walker & [motorized scooter]..." Nursing notes on 6/27/08, 7/2/08, and 7/11/08 described the patient having difficulty with ambulation, edema, and wheezing. The Medical Social Services Assessment Plan of Care & Telephone Orders form was completed on 6/24/08 by the SWA. It stated the patient was independent with ADLs "with some memory problems" and used a walker. The assessment stated the patient lived alone and had a son in a town approximately 32 miles away. The assessment stated the patient was "looking to move to Sr. Apts." The POC stated social work interventions to be provided were "Assessment of social/emotional function" and "Community resource planning: [medical alert] -Aging Office,	G 201	Please refer to the attached **Appendix I** for all plans of correction.	

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G 201	Continued From page 31 Sr. Apts". The assessment/POC was signed by the MSW on 7/6/08, 12 days later. No other documentation by the MSW was present in the record. An accompanying note by the SWA on 6/24/08, stated the patient had "just finished a 100 day stay at a (skilled nursing facility). He has great trouble getting around-uses a walker. Short of breath-diabetic-had a stroke 3 yrs ago & CHF. He lives alone in an upstairs apartment. He has a son who lives in [town name] who is POA and does his shopping-errands, etc...Referrals made to Sr. apts-where he will not be living on 2nd floor (with) stairs...Son will help him call Sr apts & go visit them. No further visits needed." The SWA, interviewed on 8/14/08 at 3:10 PM, stated the physician and nurse were concerned that the patient lived in a second floor apartment and had problems caring for himself. She said that, as of 8/14/08, the patient had not moved. She said she could not state what she had specifically communicated to other staff regarding the patients' social service needs. The social worker did not act as a consultant to staff in relation to Patient #17.	G 201	Please refer to the attached **Appendix I** for all plans of correction.	
G 323	484.20(c)(1) TRANSMITTAL OF OASIS DATA The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly. This STANDARD is not met as evidenced by: Based on data review and staff interview it was determined that the agency failed to transmit OASIS data to the State agency or CMS OASIS contractor at least monthly. The findings include: 1. A submission statistics report starting 2/01/08 and ending 7/31/08 showed that no patient data	G 323		

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G 323	Continued From page 32 was electronically transmitted for the months of 4/08 and 7/08. 2. On 8/15/08 at 9:00 AM, the agency's Clinical Support Associate/Administrative Assistant was interviewed and confirmed that there was no patient data transmission done for the months of 4/08 and 7/08.	G 323	Please refer to the attached **Appendix I** for all plans of correction.	
G 330	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary This CONDITION is not met as evidenced by: Based on medical record and agency policy review and staff interview, it was determined the agency failed to ensure the RNs completed initial assessments that were comprehensive in describing the health care/status of patients.	G 330		

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G 330	Continued From page 33 1. Refer to G331 as it relates to the failure of the agency to provide complete initial nursing assessments that were comprehensive. The cumulative effect of these systemic practicies resulted in the inability of the agency to determine patient needs.	G 330	Please refer to the attached **Appendix I** for all plans of correction.	
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by: Based on review of medical records and agency policies and staff interview, it was determined the agency failed to ensure the RN's completed initial assessments that were comprehensive and thoroughly described the health care status of 4 of 19 patients (#s 1, 3, 10, and 13), whose POCs were reviewed. The agency only used OASIS items for their comprehensive assessment. These assessment items were not sufficient to evaluate the medical status and care needs of patients. The findings included: 1. Patient #1 was admitted on 04/18/08 with a principal diagnosis of Multiple Sclerosis. Review of the initial OASIS assessment, dated 4/14/08 and conducted by the registered nurse, revealed responses to the following assessment items were omitted or incomplete: a.) Prior Hospitalizations: The assessment indicated prior hospitalizations had occurred due to exacerbation of her Multiple Sclerosis, however, the assessment did not specify the frequency or	G 331		

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G 331	Continued From page 34 exact or general dates of the hospitalizations. b.) Integumentary Status: lists edema but did not address part of body affected or the degree of edema that was present. This section also indicated the patient had bruises. However, the assessment did not describe the locations, color, size, or shape of the bruises. c.) Fall/Risk Assessment: The assessment did not include the patient's breathing problems or whether the amount of medications taken by Patient #1 might affect her risk for falls. d.) Home Environment Safety part of OASIS assessment was left blank. 2. Patient #13 was admitted for home health services on 7/09/08 with a diagnosis of cholecystectomy surgery aftercare. Review of the start of care OASIS (Outcome and Assessment Information Set) Assessment, dated 7/09/08 and completed by the registered nurse, revealed assessment areas were left uncompleted) a) Pain; The body areas affected by pain were not listed in this section. b); Integumentary Status; This section did not describe where the stasis ulcers are located. c) Medications; No medication list was present in chart until the Home Health Certification and Plan of Care were submitted. Without an accurate and comprehensive initial assessment, development of the plan of care would be indeterminate. 3. Patient # 3 was a 70 year old female whose SOC was 7/8/08. She was currently a patient as of 8/14/08. Diagnoses on the POC included muscle weakness, malignant neoplasm breast, and infection due to vascular implant. A Case Conference note, also dated 7/8/08, stated the patient had a history of breast cancer with metastasis. The "COMPREHENSIVE ADULT	G 331	Please refer to the attached **Appendix I** for all plans of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137081	A. BUILDING _____ B. WING _____	08/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOME HEALTH SERVICES	3470 WASHINGTON PKWY IDAHO FALLS, ID 83404

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G 331	Continued From page 35 NURSING ASSESSMENT" (OASIS), dated 7/8/08, stated the patient had breast cancer but did not state where else the patient's cancer was or how other cancer sites might affect the patient's care needs. The assessment stated the patient had dysphagia due to Bell's Palsy. It did not describe the patient's ability to eat or drink. The assessment stated the patient had a "Depressed mood" but did not describe what this meant. The assessment stated, at least once a week, the patient had "Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions." The assessment did not describe what this meant. The assessment stated the patient "Lives alone. Home extremely cluttered. Smells cat/dog. Pt. refuses to bathe, refuses children's help. Lies in bed most of day-incontinent & doesn't wear attends. Has had chemo but had to stop because of nerve damage in legs per family report. Pt has infected portacath site & is on Levaquin daily X 5 days. Area around portacath reddened. Pt willing to try therapy & have HHA (aide). Pt doesn't want a lot of people coming & going per family report." The assessment did not conclude if the patient was safe in the home environment and whether or not she could provide for her basic needs when staff were not present. The Clinical Coordinator was interviewed on 8/13/08 at 11 AM. She stated the OASIS assessment was the only assessment the agency used. She said no other more comprehensive assessment had been completed for this patient. She stated the agency was transitioning to a computerized assessment. The new assessment was reviewed at the time. It was not apparent that the new assessment was more comprehensive than the old assessment. The Clinical Coordinator, interviewed again on	G 331	Please refer to the attached **Appendix I** for all plans of correction.	

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G 331	Continued From page 36 8/22/08 at 3:55 PM, stated the agency did not have a policy directing nursing staff on the completion of a comprehensive assessement. 4. Patient # 10 was a 68 year old female whose SOC was 12/19/07. She was discharged and admitted to a hospital on 1/3/08. Diagnoses included total hip replacement on 11/26/07, decubitus ulcer, and diabetes. Home health was ordered because the patient was moving from the SNF to a private residence. A referral sheet was faxed to the agency from the SNF where the patient resided on 12/18/07. The cover sheet stated "Adult Protection referral has been made." A nursing assessment was conducted on 12/19/07. The assessment documented the patient was an insulin dependent diabetic but the BG was not documented and the patient's diabetes, e.g. the stability of glucose levels, patient/caregiver compliance with diet and medications, was not assessed. The issues regarding the referral of the patient to Adult Protection were not assessed as part of the comprehensive assessment. Following the lack of a complete patient assessment, a POC was developed which did not include diabetes care and monitoring for potential abuse. The patient's BG remained very high (300->500) while she was on service. The patient's husband reported the patient had a seizure on 12/26/07, which occurred when the patient's BG was >500. Evidence of possible abuse was also documented during the patient's admission. The RN Case Manger for Patient #10 was interviewed on 8/13/08 at 3:50 PM. She reviewed the medical record and confirmed the assessment and POC did not address the patient's diabetes or potential abuse. She said	G 331	Please refer to the attached **Appendix I** for all plans of correction.	

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G 331	Continued From page 37 she had known the patient prior to her admission to home health and she did not take the patient's situation as seriously as she should have.	G 331	Please refer to the attached **Appendix I** for all plans of correction.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the recertification survey were: Gary Guiles, RN, HFS, Team Leader Sylvia Crestwell, NLTC Supervisor Patrick Hendrickson, RN, HFS Sharon Mauzy, RN, HFS Acronyms used in this report: ADL = Activity of Daily Living ALF = Assisted Living Facility BG = Blood Glucose level HHA = Home Health Agency IADL = Instrumental Activity of Daily Living MRSA = Methicillin-resistant Staphylococcus MSW = Medical Social Worker OASIS = Outcome and Assessment Instrument Set Ph.D. = Doctor of Philosophy POA = Power of Attorney POC = Plan of Care SNF = Skilled Nursing Facility SOC = Start of Care SWA = Social Work Assistant	N 000	Please refer to the attached **Appendix II** for all plans of correction.	
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency	N 051	RECEIVED SEP 22 2008 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 9/19/2008

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 051	Continued From page 1 and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations. This Rule is not met as evidenced by: Refer to G 141 as it relates to the agency's failure to maintained Personnel records of staff working directly with patients contained current licensure. The findings include: 1. Personal records did not include current copies of professional licenses.	N 051	Please refer to the attached **Appendix II** for all plans of correction.	
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to Federal deficiency G 176, as it relates to the failure of the agency to ensure the registered nurse informed the physician of changes in the patient's condition and needs. The findings include:	N 098		

Bureau of Facility Standards

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N 098	Continued From page 2 1. Nursing staff did not notify physicians of changes in patient's condition.	N 098	Please refer to the attached **Appendix II** for all plans of correction.	
N 151	03.07030.PLAN OF CARE N151 030. PLAN OF CARE. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's plan of care. This Rule is not met as evidenced by: Refer to Federal deficiency G 158 as it relates to the HHA's failure to ensure that care followed a written plan of care established by a physician. The findings include: 1. Staff altered patient's POC's by providing extra visits or missing scheduled visits. Additionally, there was a significant delay in the evaluation and treatment for a patient who was ordered to receive OT services and developing a POC for nursing services.	N 151		

Aspen Home Health
Blackfoot Home Health
Medicare Provider # 13-7081
State License Number HH183
August 29, 2008 Survey
HCFA-Identified Deficiencies Credible Allegation

Appendix I

Aspen Home Health
Blackfoot Home Health
Medicare Provider # 13-7081
State License Number HH183
August 29, 2008 Survey
HCFA-Identified Deficiencies Credible Allegation

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G141	All personnel files were reviewed for accuracy and completeness. Missing information was added to files as appropriate. Files will be reviewed quarterly for completeness and accuracy.	Jenny Anderson	Ongoing	09/03/08
G158	All staff were inserviced regarding need to follow all visit frequencies on POC. Any case conference notes regarding missed visits or delays in service will be faxed to MD for notification. Quarterly QI review of 25% of all active patient records to assess compliance with MD notifications and visit/orders consistency.	Deanna Baird RN Kathy Huntsman RN	Ongoing	09/19/08
G159	All clinical staff members were inserviced regarding the need to include timely discharge considerations as part of the overall ongoing patient plan of care.	Deanna Baird RN Kathy Huntsman RN	N/A	09/19/08
G173	Clinical staff members were inserviced regarding the need to update all plans of care with abnormal findings, changes in patient status, pain level, family dynamics and disease processes. Such updates will include added interventions in the POC. The staff were also instructed to include documentation of all physician responses to the above in the patient record.	Deanna Baird RN Kathy Huntsman RN	N/A	09/19/08
G176	Clinical staff were inserviced regarding the need to document changes in patient condition thoroughly in the patient record, and also to notify attending MD of any and all changes. Additionally, the staff were instructed to carefully document any information they may have that would verify MD received the patient change information, and to include any physician feedback to the changes..	Deanna Baird RN Kathy Huntsman RN	N/A	09/19/08

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G194	Please see responses to G195, G196, and G201			09/19/08
G195	The medical social services policy was revised by a team that included the agency's clinical directors, QSW and SWA. This revised policy clarifies all aspects of the service including supervision of the SWA by the QSW. The QSW and SWA are following the guidelines of the revised policy. Agency forms were revised to provide better documentation of services being provided and the ongoing MSS activities. The agency's QSW will continue review all initial POC developed by the SWA and document said reviews in writing in the patient record. The agency does not conduct IDT meetings. Therefore it is not possible for the QSW to attend such meetings. The agency does conduct monthly case conferences that include all disciplines. When the SWA represents social services at this meeting the QSW will review the coordination of care note and document said review in writing in the patient record.	Deanna Baird RN Kathy Huntsman RN Frank Dalley PhD Kathy Jensen BSW	Ongoing	09/19/08
G196	The agency's QSW was instructed to continue reviewing all plans of care, and to document said reviews and interactions with the SWA in writing, and to include all such documentation in the patient record.	Deanna Baird RN Kathy Huntsman RN Frank Dalley PhD Kathy Jensen BSW	Ongoing	09/19/08
G201	All patients currently receiving social service visits will be reviewed at the monthly case conference meeting.	Deanna Baird RN Kathy Huntsman RN Frank Dalley PhD Kathy Jensen BSW	Ongoing	9/11/2008
G323	Agency OASIS coordinator disciplined, and instructed to submit OASIS information monthly.	Robert Collette	Ongoing	08/23/08

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G330	Please see response to G 331	N/A	N/A	N/A
G331	All clinical staff were inserviced on the need to do a comprehensive clinical assessment at admission that accurately reflects the patient's current health status. This assessment shall include narrative, where appropriate, to detail abnormal findings or other aspects of the patients' condition that are not covered in the comprehensive OASIS data set. Clinical staff are reviewing all existing patients' assessments and adding narrative where appropriate. This narrative is being included in the patient record.	Deanna Baird RN Kathy Huntsman RN	Ongoing	09/11/08 09/19/08

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Appendix II

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State-Identified Deficiencies Credible Allegation

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N051	Please see response to Federal ID G141	N/A	N/A	N/A
N098	Please see response to Federal ID G176	N/A	N/A	N/A
N151	Please see response to Federal ID G158	N/A	N/A	N/A